

MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS PROTOCOL

SUBJECT: Gamma Knife		Protocol #: PA P169.01	
APPLIES TO: MHP <input checked="" type="checkbox"/> MLTCP <input checked="" type="checkbox"/> MSSP <input checked="" type="checkbox"/> HEALTHSELECT <input checked="" type="checkbox"/>		Protocol Pages: 1 Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Initial Effective Date: June 1999 Latest Review Date: May 2002	
MIHS HEALTH PLANS APPROVALS:			
Director, Medical Management _____		Date: _____	
Medical Director: _____		Date: _____	

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Gamma Knife.

PROTOCOL:

- A. Gamma Knife (Stereotactic Surgery)
LOS: IP, 1 day
- B. The prior-authorization specialist may approve if **all** of the following are present:
 - 1. Small AVM in difficult to reach location,
 - 2. Conventional surgery is contraindicated,
 - 3. Lesion less than 3.5 cm **and**
 - 4. Second opinion supports use of Gamma Knife.
- C. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.
- D. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.
- E. If requirements are not met, Medical Director review is required.

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.